uals with a lesser degree of β-cell failure, those who do not have type I diabetes but true pre-type I diabetes.

It will be hard to define the risk-benefit ratio in such "normoglycemic yet insulinopenic" populations, considering the spectrum of potent immunosuppressant drugs currently available. Critical questions relate to administering these agents to young children, determining the period of time that the agent must be used and, even more importantly, defining tests that are specific and sensitive enough to indicate the lack of progress of the immunodefect and β-cell function or reduction of the autoimmune defect and the reversal of the impaired insulin secretion.

Another crucial issue is the design of such studies. Without having sufficient information concerning the natural history of all of the features of type I diabetes, appropriate experimental design and subject inclusion criteria are difficult to establish.

A controlled randomized study design is obviously one that has to be given serious thought. This raises the spectre of an expensive, complex, multicenter clinical trial, but considering the importance of the possibility of postponing or preventing type I diabetes, this could be an issue that deserves considerable support.

The language, semantics and definitions that have to be used in communicating thoughts, ideas, plans and progress may also need refinement. Some of the words that bother me are "remission," "control," "insulin-dependent" and "β-cell function."

The establishment and encouragement of ongoing workshops and comparison groups related to assays used in assessing immunotherapy have been and will continue to be an important component in handling this difficult problem. The superimposition of some type of a clearinghouse mechanism to improve this networking would be gratefully received by all workers in the field.

Finally, this is now a key and crucial time for the type I diabetic constituency to play their role and to make their mark. High-risk groups—those with diabetes multiplex, monozygotic twins discordant for type I diabetes mellitus, first-degree relatives of type I diabetics—should be encouraged to learn more about what their contributions to this effort might be. The health agencies such as the American Diabetes Association, local diabetes societies, the Juvenile Diabetes Foundation and the like should educate to ensure that the diabetic constituency (and the direct benefactors of such clinical research) could play an informed and enlightened role as true collaborators. "Let the people be heard."

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Is the Dollar Mentality in Health Care Healthy?

THE DOLLARS in health care are important. There is no gainsaying this. But are the dollars what health care is really all about? Is it actually healthy to shift health care dollars away from what appear to be excessive costs toward profits that benefit institutions and persons that may only have a dollar incentive to provide the health care that is needed? One senses that somehow something is wrong and that somehow this is not healthy. There is already reason to believe that the present preoccupation with dollar costs and dollar profits, with only relatively superficial lip service to the access and quality of services that are needed by many, may be seriously eroding what health care is all about. It seems almost to go without saying that health care should especially be for those who need it most. And this could be any of us.

The "dollar mentality" in today's health care focuses on dollars, not people. Cost conscious governments, national, state and even local, are de facto no longer able to cope, and are withdrawing needed care for the indigent sick, not to mention the homeless, because of the dollar costs. Private enterprise, whether in business or industry or health care, also needs to keep costs down. Even hospitals are moving the "bottom line" further up on their lists of purposes and priorities, no doubt influenced if not impelled by the government imposed system of DRG payments for services to Medicare patients. And, even of greater concern, more and more physicians and other health professionals are developing, often of necessity, a similar dollar mentality with respect to where and how they will conduct their practices.

How can all this be healthy for health care? If it is true, as some are beginning to believe, that the only goal of health care is simply someone's financial gain or profit, then yes, all of this is healthy for the health care system. But there are many, and this author hopes that we are in a majority, who believe that the health care system is less for profit than for adequate access and quality of care for those who need its services—that is, the sick, injured and emotionally disturbed—as well as to promote the health and well being of those who are not yet sick. What then is the relationship between a financially healthy health care system and a system that provides adequate health care services for all those who need them? This would seem to be the nut of a great big problem.

In the real world of economics it is unlikely that it will ever be found financially profitable to care for the very ill, those who cannot pay, the homeless, the underfed or any of the disadvantaged. Indeed governments, business, industry, hospitals and even health care providers have found this to be true, or soon will. The fact is, that in the present health care environment, it is simply not in the cards for a profit oriented health care system to provide adequate care where the need is greatest. And it is also true that in the long run it cannot be in the social, economic or political interest of the nation as a whole to allow the dollar mentality in health care to go so far as to displace the real purpose of our health care system. The answers will not be easy, but they must be found before we sacrifice what health care is all about to this dollar mentality that now seems to prevail so widely with respect to health care in this nation.

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